



## **Texas Department of Insurance**

### **Division of Workers' Comp**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ALLIED MEDICAL CENTERS  
PO BOX 24809  
HOUSTON TX 77029

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

AMERICAN HOME ASSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-1777-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Austin Radiological Association has provided services in good faith to a patient who presented as an injured employee and Worker's Compensation Claimant..."

**Amount in Dispute:** \$58.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "It is the carrier's position that per a Decision and Order dated March 5, 2010 and an Appeals Panel Decision dated August 9, 2010, this claim has been adjudicated as noncompensable. Additionally, Chartis is the Third Party Administrator for American Home Assurance Company which does not provide workers' compensation coverage for the above claimant per the same Decision and Order and Appeals Panel Decision."

**Response Submitted by:** Chartis; 4100 Alpha Road Ste 700; Dallas TX 75244

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2010	99212	\$58.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §413.042 (a)(1) sets out the procedures for health care providers to pursue a private claim against an injured employee.

### Issues

1. Has the compensability of this claim been finally adjudicated?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement?

### Findings

1. The respondent submitted a copy of a Contested Case Hearing that was held on March 5, 2010 to determine the compensability of the claimant's injury. The hearing officer ruled that the injured employee did not sustain a compensable injury and failed without cause, to timely report such alleged injury. The respondent also submitted the Appeals Panel Decision which affirmed the hearing officer's decision and became final on August 9, 2010.
2. Texas Labor Code §413.042 states in pertinent part that "(a) A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the provider unless: (1) the injury is finally adjudicated as not compensable under this subtitle..."
3. The requestor is not entitled to reimbursement by the respondent as the injured employee did not sustain a compensable injury in the course and scope of his employment.

### Conclusion

For the reasons stated above, the requestor has failed to establish that reimbursement is due and medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### Authorized Signature

_____	_____	May , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**